

# **EXHIBIT A**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH  
VITAL STATISTICS**

CASE FILE NO. 3930514

**CERTIFICATE OF DEATH**

2016022831

STATE FILE NUMBER

TYPE OR  
PRINT IN  
PERMANENT  
BLACK INK

**DECEDENT**

IF DEATH  
OCCURRED IN  
INSTITUTION SEE  
HANDBOOK  
REGARDING  
COMPLETION OF  
RESIDENCE  
ITEMS

**PARENTS****DISPOSITION****TRADE CALL****CERTIFIER****REGISTRAR****CAUSE OF DEATH**

CONDITIONS IF  
ANY WHICH  
GAVE RISE TO  
IMMEDIATE  
CAUSE  
STATING THE  
UNDERLYING  
CAUSE LAST

1a. DECEASED-NAME (FIRST,MIDDLE,LAST,SUFFIX) <b>George Wayne WATTS</b>		2. DATE OF DEATH (Mo/Day/Year) <b>December 15, 2016</b>		3a. COUNTY OF DEATH <b>Clark</b>	
3b. CITY, TOWN, OR LOCATION OF DEATH <b>Las Vegas</b>		3c. HOSPITAL OR OTHER INSTITUTION -Name(If not either, give street and Inpatient(Specify) <b>9413 White Ridge Avenue Home</b>		4. SEX <b>Male</b>	
5. RACE (Specify) <b>White</b>		6. Hispanic Origin? Specify <b>No - Non-Hispanic</b>		7a. AGE-Last birthday (Years) <b>79</b>	
7b. UNDER 1 YEAR <b>MOS</b>		7c. UNDER 1 DAY <b>HOURS</b>		8. DATE OF BIRTH (Mo/Day/Yr) <b>[REDACTED]</b>	
9a. STATE OF BIRTH (If not US/CA, name country) <b>Arkansas</b>		9b. CITIZEN OF WHAT COUNTRY <b>United States</b>		10. EDUCATION <b>12</b>	
11. MARITAL STATUS (Specify) <b>Married</b>		12. SURVIVING SPOUSE'S NAME (Last name prior to first marriage) <b>Nancy Louise WATTS</b>			
13. SOCIAL SECURITY NUMBER <b>[REDACTED]</b>		14a. USUAL OCCUPATION (Give Kind of Work Done During Most of <b>Fire Captain</b>		14b. KIND OF BUSINESS OR INDUSTRY <b>Fire &amp; Rescue</b>	
15a. RESIDENCE - STATE <b>Nevada</b>		15b. COUNTY <b>Clark</b>		15c. CITY, TOWN OR LOCATION <b>Las Vegas</b>	
15d. STREET AND NUMBER <b>9413 White Ridge Avenue</b>		15e. INSIDE CITY LIMITS (Specify Yes or No) <b>Yes</b>			
16. FATHER/PARENT - NAME (First Middle Last Suffix) <b>Byron WATTS</b>			17. MOTHER/PARENT - NAME (First Middle Last Suffix) <b>Gertrude HENLEY</b>		
18a. INFORMANT- NAME (Type or Print) <b>Nancy Louise WATTS</b>		18b. MAILING ADDRESS (Street or R.F.D. No, City or Town, State, Zip) <b>9413 White Ridge Avenue Las Vegas, Nevada 89149</b>			
19a. BURIAL, CREMATION, REMOVAL, OTHER (Specify) <b>Cremation</b>		19b. CEMETERY OR CREMATORY - NAME <b>Palm Crematory</b>		19c. LOCATION City or Town State <b>Las Vegas Nevada 89101</b>	
20a. FUNERAL DIRECTOR - SIGNATURE (Or Person Acting as Such) <b>JAYE D MACPHERSON</b> <b>SIGNATURE AUTHENTICATED</b>		20b. FUNERAL DIRECTOR LICENSE NUMBER <b>FD202</b>		20c. NAME AND ADDRESS OF FACILITY <b>Neptune Society</b> <b>8570 Del Webb Blvd Las Vegas NV 89134</b>	
TRADE CALL - NAME AND ADDRESS					
21a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated (Signature & Title) <b>CRAIG M JORGENSEN M.D.</b> <b>SIGNATURE AUTHENTICATED</b>		22a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature & Title)			
21b. DATE SIGNED (Mo/Day/Yr) <b>December 17, 2016</b>		21c. HOUR OF DEATH <b>07:17</b>		22b. DATE SIGNED (Mo/Day/Yr)	
21d. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)		22d. PRONOUNCED DEAD (Mo/Day/Yr)		22e. PRONOUNCED DEAD AT (Hour)	
23a. NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, ATTENDING PHYSICIAN, MEDICAL EXAMINER, OR CORONER) (Type or Print) <b>Craig M Jorgenson M.D. 6330 S Jones Blvd Las Vegas, NV 89118</b>					23b. LICENSE NUMBER <b>9529</b>
24a. REGISTRAR (Signature) <b>NANCY BARRY</b> <b>SIGNATURE AUTHENTICATED</b>		24b. DATE RECEIVED BY REGISTRAR (Mo/Day/Yr) <b>December 19, 2016</b>		24c. DEATH DUE TO COMMUNICABLE DISEASE <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
25. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)					
PART I					
(a) <b>Dementia</b> DUE TO, OR AS A CONSEQUENCE OF:					
(b) <b></b> DUE TO, OR AS A CONSEQUENCE OF:					
(c) <b></b> DUE TO, OR AS A CONSEQUENCE OF:					
(d) <b></b> DUE TO, OR AS A CONSEQUENCE OF:					
PART II OTHER SIGNIFICANT CONDITIONS-Conditions contributing to death but not resulting in the underlying cause given in Part 1.					26. AUTOPSY (Specify Yes or No) <b>No</b>
27. WAS CASE REFERRED TO CORONER (Specify Yes or No) <b>Yes</b>					
28a. ACC., SUICIDE, HOM., UNDET. OR PENDING INVEST. (Specify)		28b. DATE OF INJURY (Mo/Day/Yr)		28c. HOUR OF INJURY	
28d. DESCRIBE HOW INJURY OCCURRED					
28e. INJURY AT WORK (Specify Yes or No)		28f. PLACE OF INJURY- At home, farm, street, factory, office building, etc. (Specify)		28g. LOCATION STREET OR R.F.D. No. CITY OR TOWN STATE	

LOCAL REGISTRAR

"CERTIFIED TO BE A TRUE AND CORRECT COPY OF THE DOCUMENT ON FILE WITH THE REGISTRAR OF VITAL STATISTICS, STATE OF NEVADA." This copy was issued by the Southern Nevada Health District from State certified documents authorized by state Board of Health pursuant to NRS 440.175.

VRS-Rev-20120523a



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DATE ISSUED:

DEC 20 2016

Registrar of Vital Statistics

By: *[Signature]*

This copy not valid unless prepared on watermarked security paper displaying date, seal and signature of Registrar.  
SOUTHERN NEVADA HEALTH DISTRICT • P.O. Box 3902 • Las Vegas, NV 89127 • 702-759-1010 • Tax ID # 88-0151573